

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

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10:18 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Monitoring beneficiary access to care
-- Karen Milgate, Jill Bernstein, Mae Thamer-Nall

MS. MILGATE: As Glenn said, this discussion is a continuation of last month's on the most effective way to monitor beneficiary access to care.

At the last meeting, the commission discussed the variety of data sources to be considered and determined which types of analyses to pursue. At this meeting, we'll discuss how the monitoring system would work and actually begin to use it. Today Mae will present an overview about what is already known about beneficiary access to care, looking through direct measures of access which is described as step two in the flow chart that we'll go through in a couple of minutes.

So what do we mean by access? The definition that the IOM developed is the timely use of personal health services to achieve the best possible health outcome. To determine how to measure access, it is also useful to describe its various dimensions, and you may remember some of these from the last meeting.

The first question that is important to ask is whether there is enough capacity to actually meet beneficiary needs. So here you might want to look at the supply of providers, whether the type of providers are appropriate, and match them up with whether in fact those types of providers are able to meet the beneficiary needs.

Even if there is enough capacity to meet the beneficiary needs, there may be other obstacles for beneficiaries to obtain care. So the second question is whether beneficiaries are actually able to obtain services.

And then the third step is whether the services they obtain are appropriate. They may obtain services but, in fact, they aren't the right services.

It's pretty hard to see the screen from here, so you may want to look at the chart that you have in front of you, from the handouts.

So how would MedPAC's monitoring system work? Because the questions asked and data sources used often create very different impressions about beneficiary ability to access care, our monitoring system is designed to look at access from many different angles. In particular, it's important to understand that Medicare beneficiaries access to care is shaped by factors specific to Medicare, but it's also shaped by factors that are not specific to Medicare that impact the entire health care system.

You'll see on the chart here that, on the left-hand side, we've looked at the timing of the analyses. In the middle we have a description of the various analyses. And then on the right-hand side, we look at the outcome of the process or the products that might be created by these analyses.

The first step is that we would look at the health system capacity. So here we would determine whether the system has the capacity to meet beneficiary needs. So it would be important to

look at both what beneficiaries look like and what their needs are, and then also whether the supply of providers and types of providers are appropriate. So we would look at the age of beneficiaries, disability status, insurance status, income, prevalent conditions, and also where they live.

Providers, we'd look at the supply of facilities, physicians, certain specialists, nurses and other health professionals, entry and exit, and perhaps we'd take a special look at any new types of services or settings that may have become important to the Medicare program.

You can see here, too, in this step of the analysis, there would be quite an interaction between the analysis we do for payment adequacy and update purposes and the analysis we do for access purposes. We believe there would be quite a bit of interaction and that the two analyses would actually feed on and enhance the other.

Some of the products that would come out of this would be some information that would be used for payment adequacy in the update framework.

The second step of the process, after looking at whether the capacity is appropriate, is to look at actual direct measures of access. This particular box is highlighted because this is the type of information we were going to present to you today.

Here we would look at general measures from sources such as beneficiary and provider surveys and utilization data, to get some general sense of access to care. And then it would also be important to break it down into distributional measures such as socioeconomic status, which is an analysis we are intending to do, as well as to do local market analysis.

I want to stop for a moment on the concept of local market analysis, because that was an area that the commission was very interested in and is, of course, very important to get a real picture of access that gets below the national data level.

There we have several efforts underway, but in particular I wanted to highlight some work that CMS is doing that we are talking with them to work with them on. They're taking the CAHPS fee-for-service data, which in fact we talked about last time as being a fairly large sample of beneficiaries, and using that in tandem with some hot spot analysis where they've gotten some information from carriers and their 1-800 number, and some local surveys of agencies to actually target some specific geographic areas where they might do some more in-depth surveys of beneficiaries to understand the reasons for access problems.

So that's a piece of analysis that we hoped to work with CMS closely on, and that would enhance some of our work in that area, as well.

In addition to looking at distributional measures, we'd also then want to look at measures of appropriate use. So we'll be looking at some data that will give us some sense of use of preventive services and preventable hospitalizations.

These two steps together would give the commission some sense of the types of issues you might want to delve into in some more detail. And so, between those two steps and the second two, which are more of the policy grinding steps, we'd want to stop

and say okay, these are the issues that seem to be coming up on their horizon. Let's go and dig in some more detail to understand the reasons for those patterns.

This year the issues that we talked about at the last meeting were looking in some detail in physician office setting, post-acute care, doing the socioeconomic status analysis so we'd look at the interrelationship between some of those factors, and then a more in-depth analysis of trends in the emergency department to try to get a sense of what they might tell us about access to services outside of the emergency department and also access to services within the emergency department.

So the third step then would be the first step in the policymaking process, is really to determine whether and why a problem exists and how it may be related to Medicare policy. Is this particular problem driven by factors that are outside of the control of the Medicare program? Or is there, in fact, some way that a Medicare policy may be driving the issue?

And then the fourth step would be to analyze policy options and to develop recommendations. So here, whether it was Medicare's policy that was the issue, or something more broad than that, to determine whether in fact Medicare could and/or should try to address the problem.

So those are the four steps of the analysis. And you can see on the right-hand side, the product that we envision coming out of this could include special issue reports if the commission felt there was a particular issue that we wanted to have an actual report out there on the one issue, but would also feed into our March report through payment adequacy updates, payment adequacy in the update process, other chapters, or it could also be included in the June report to Congress.

Today, as a first step in our analysis, Mae is going to present an overview of what we know about access through looking at types of data that are described in step two or direct measures of access.

DR. THAMER-NALL: Good afternoon. As Karen said, today I will be presenting an overview regarding access to care among the Medicare population.

The most commonly used indicators of access are presented here. As I go along in the presentation, I'll discuss some of the limitations and advantages of using various indicators to access. The following slides provide you with an overview of beneficiary access to care based on the most recent and widely used nationally representative health care surveys.

The next few slides suggest that, in general, most people perceive themselves as having good access to care. I'll start with a comparison of access to care for elderly persons versus other populations. When we examine specific potential access problems in the future, we hope to always first examine if these problems are also found in the wider health care system, and may not therefore be a result of a specific Medicare payment or other policy.

In general, looking at this slide, the elderly appear to have better access to care compared to younger persons. Adults age 18 to 64 are two or three times as likely to report failing

to get care in the past year because of financial barriers compared to older Americans.

In this slide we're showing you data for the first quarter of 2002 for illustrative purposes only. Although it's not statistically significant, it shows you an increase in the percent of women over 65 that report access problems from 2.3 percent to 3.0 percent. I want to point out that this is noteworthy because it runs counter to trends over the past decade that have been observed in this survey as well as others. And therefore it may merit further scrutiny when we get more complete data for 2002.

In other words, this is the kind of timely information that we would be sure to follow up on using our monitoring access database.

DR. REISCHAUER: Can I ask a technical question? Is the 2001 number the average of four quarterly administrations of this question? Or is during 2001 did you not receive care and then you're comparing it to the same question asked at the end of the first quarter of 2002, which includes three-quarters of 2001?

DR. THAMER-NALL: The specific question in NHIS is during the past 12 months was there any time when someone in your family needed the care --

DR. REISCHAUER: Right, but do they collect this information quarterly?

DR. THAMER-NALL: My impression is yes, it's collected quarterly.

DR. REISCHAUER: So the 2001 number, part of it would refer to 2000? Okay, fine.

DR. THAMER-NALL: Yes.

I apologize that this slide is a little difficult to read. The point here is that in addition to having few access problems, on two of the three measures of perceived access to care that are asked in the Medicare current beneficiary survey, access problems appear to be declining between 1991 and 2000. One possible factor in the general improvement in access to care may be the increase in the proportion of elderly that report a usual source of care over this period. That's gone up from 90 percent to about 94 percent.

Although Medicare has been largely success in ensuring access to care for most beneficiaries, certain subgroups appear to have less access than others. I can see that's very difficult to see from this distance, but hopefully you have it in front of you.

For example, the disabled beneficiaries were almost twice as likely to report trouble getting care, and almost one-fifth reported delay in care due to cost. Low income beneficiaries were also more likely than those with higher incomes to report problems obtaining care or delaying care because of costs.

Similarly and notably, 17 percent of those in poor health said that they delayed care due to costs compared to only 3 percent in excellent or very good health. And 10 percent of those in poor health reported trouble getting care.

Rural beneficiaries were somewhat more likely to report delay in care due to costs compared to urban beneficiaries. And

finally, beneficiaries without any form of supplemental coverage, and that means including employer-sponsored Medigap or Medicaid, and this comprises one out of 10 beneficiaries, have reported serious access problems. 20 percent of those without any supplemental coverage reported delay in care due to costs and 17 percent had no usual source of care.

As you know, most elderly care supplemental insurance, which appears to have a strong influence under access to care, for a number of preventive and clinically necessary services. On this slide, with regard to access to clinically necessary services for the elderly that's shown here and that's been employed by the commission in previous work, significant differences exist.

In order to save time, let me just summarize the findings by reporting first of all the overall use of necessary ambulatory services for specific chronic conditions such as diabetes, congestive heart failure, COPD, is low overall compared to inpatient care for acute episodes.

However, beneficiaries with supplemental coverage are significantly more likely to use the recommended procedures and, in some cases, have a lower incident of avoidable outcomes compared to beneficiaries without any form of supplemental coverage.

The percentage of elderly without any supplementation to Medicare vary significantly by race. In 1999, according to data provided by my colleague, Chantal, 18 percent of African-American beneficiaries had no additional coverage other than Medicare. That's compared to 14 percent of all Hispanics and 7 percent of white beneficiaries, numbers a little bit different from the stats that were provided in your briefing materials.

DR. ROWE: Is that traditional Medicare?

DR. THAMER-NALL: Traditional Medicare.

DR. ROWE: Not Medicare+Choice.

DR. THAMER-NALL: That's right.

Minority beneficiaries are less likely to have a usual doctor, 91 percent of whites versus 80 percent of blacks and 78 percent of Hispanic beneficiaries. And they're more likely to use a hospital emergency room or urgent care center for their care. That's 2 percent of whites versus 10 percent of blacks and 10 percent of Hispanics.

This is important because beneficiaries may be more likely to receive preventive services and possibly better continuity of care in a doctor's office compared to an emergency department when it's used as a regular source of care.

So in concluding a very brief overview of access to care, I want to make a few points. National estimates of access serve as valuable benchmarks, however they may obscure variations that are based on beneficiary characteristics or geographic regions, which we did not look at here. Although the majority of elderly report good access to care, those without supplemental insurance, minorities with low incomes, and those in poor health may experience access problems. And we plan to analyze the interrelationships among these various factors to better understand what related policy options might be.

The next steps include more depth analysis of trends in

emergency departments and the role of socioeconomic status. Finally, we hope to have a draft chapter report for the March 2000 report on access to care by December.

MR. DURENBERGER: Let me ask a question which is related. I guess the best way to express the question is access to what? And it's sort of like how do people answer questions? How do you phrase the question so you get the answer that you need?

I'll just use an example that's been bothering me because it's reflective of capacity problems in our community. It doesn't seem to vary with whether you're Medicare eligible or something else. But if you look at the rise in the use of concierge care in the Seattle area, where I think it costs something like \$4,000 or \$5,000 per year to get your own doctor and get some consistency, as people think of it. Or in our community, in Minneapolis in particular, where the startup costs is \$3,000 to do the same thing.

The average age of the people enrolling is slightly over 62 years of age, which somehow suggests to me either that those are the only people with the money to pay for access, but behind that it reflects, I think, a dissatisfaction with access, whether it's expressed in being able to get the same doctor each time, being able to have my questions answered, whatever the case may be.

People who are willing to pay that kind of money in the two communities that I've just mentioned, in order to "get some kind of an assurance" of care in the system, seems to suggest something that I'm not sure these figures would suggest.

I see now you will go into some of the socioeconomic issues and so forth. But I'm wondering if either anybody on the commission or those of you who have been doing this analysis know what's behind the fact that the average 62-year-old, that that's the age average of people going into concierge care in those kinds of communities?

The question I'm trying to ask is the adequacy of the kinds of questions that we ask people, the way in which we measure either satisfaction with "access" or with care or something like that. I don't have the answer. I'm just trying to figure out what's the significance of that in the communities I've talked about.

DR. REISCHAUER: Dave, how many people are there? Couldn't you fit them all in this room? There are small groups of people who engage in strange behavior everywhere.

MR. DURENBERGER: I can't give you the Seattle numbers but it's in the several thousands. But the program has only been open in Minneapolis for six months or something like that. I don't know whether it's a fad in America or it's a growing phenomenon.

DR. ROWE: One comment on that, it's also becoming increasingly prevalent in Boston, is I think it's important to understand that, in most cases, to my knowledge, is that physicians who have established concierge practices, where they get almost a retainer payment from patients and they have longer visits and less waits and everything else, are generally converting from another practice that they had of internal medicine or family practice or whatever to a concierge practice.

And they generally bring their patients with them.

So if you look at the patients who are signing up in concierge practices, they are patients who were in these practices with these doctors before, and are a selection of those patients who can afford it and don't want to lose that doctor, et cetera. That's certainly what happened with Dr. Flyer and his colleagues in Boston.

And so if it's a practice of internal medicine, it may be in fact largely an adult and perhaps even older population. So that may have something to do with it. It's just not people from the general community who are going and signing up for these things. They're coming with the docs into the practice.

MR. DURENBERGER: The other reason I'm asking the question is that the two cases I'm thinking of are both the major multi-specialty clinics in those two communities, which you wouldn't normally think that's where this sort of thing would get -- at least, I wouldn't think that's where it would get started.

MS. MILGATE: Can I just make a comment on that? I think the way that it does possibly interact with what we're looking at doing is -- I've also heard about some -- I hesitate to call them trends because I don't know if they're really going to become trends or not -- other types of providers trying to find profit-maximizing procedures and then just focusing on those.

And to the extent that might create access problems for Medicare beneficiaries, who then don't have as much ability to obtain other services, I would think that might be an issue. Maybe in some markets, for example, physicians might take fewer Medicare beneficiaries because they have such a good concierge practice. So to me, that's how it would interact.

MR. DURENBERGER: That's not what's going on.

MR. FEEZOR: One of the things when we do our datasets in comparing the over-65 to the under-64, particularly I guess your first slide that dealt with percentage of persons who failed to obtain care, I wonder if we can we may want to look at trying to subdivide that and say 50-to-64. Those would be people who are likely to have maybe a higher use factor who would have been plugged in to physicians. And it may be a better comparison. So just as a suggestion on that, Mae and Karen.

And then the other thing, I always worry about the snapshot in time, that we only have data through 2000, and I suspect there's been a significant deterioration in some of the access measures, but that's a problem we always face.

I guess the other question I thought I had was somewhat tangential to what Dave's questions were, and the fact that when we talk about access to services we keep thinking of physical or health services or professional services.

If you look at the IOM definition, it very clearly says personal services. This may be a little too futuristic, but we probably need to start thinking about access, again access to what? Access to information and decision supports that also help individuals, indeed Medicare individuals, better manage and know about their own care.

I think one of the things that the concierge service provides -- and by the way we do have some of that happening in

California, but then we're sort of known for our deviate behavior. Interestingly enough, it tends to be physicians who, I think, want a different lifestyle and can sort of capitalize on some either insecurity or their market in taking some patients with them.

But I think it's not just that -- I can probably get the flu shot I need, but it is more of a sense of security that Dave was talking about. And if I have someone who can help me give me that advice, okay it's a concierge doctor practice, it may very well be a nurse 24 line that a lot of the consumer driven products in the under-65 markets are talking about using, information decision support.

And so I think going forward, and again this is out, that when we start talking about access for our Medicare eligibles, we have to start thinking also in information services because I think increasingly that's what care is all about.

DR. NELSON: I want to commend you for this, for a very comprehensive and broad approach to this. My question has to do with how timely the data will be when we make our March report, and specifically, whether we will be able to capture changes that were reflected in this year's cuts? Whether the current beneficiary survey will be current and be able to reflect '02 data? I presume that the National Center for Health Statistics, the NHI survey, will capture '02 data.

Do you think that we'll be able to give an adequate contemporaneous picture of this to Congress in March?

MR. HACKBARTH: Alan, we do have the survey that Kevin briefed us on last meeting, which was specifically designed to give us some timely data on access to physician services for Medicare beneficiaries.

MS. MILGATE: That's the most recent information we'll have for the March report on physicians, will be our own.

MR. HACKBARTH: The caveat there, of course, is that we're talking about a relatively small sample and no ability to slice it by specialty or location, because the numbers are just too small. But that's the tradeoff for timeliness.

DR. NELSON: The point that I'm making is the strength of having multiple data sources in our report and the wish that they'll be sufficiently current to carry that strength with it, in addition to our survey. Our own survey is going to be criticized as yes, it's this year but it was early in the year before people had a chance to really digest the impact.

MR. HACKBARTH: Although we do have evidence there that they were -- I can't remember the percentages, but a high percentage of the physicians said that they were aware of the cuts.

DR. REISCHAUER: But it's conceivable that by the time we issue our report there will be another 4.4 percent cut.

MS. MILGATE: We won't have 2002 for the MCBS, but if it's possible to get from CMS, they do have 2001 CAHPS information. They don't have 2002. So that would give us a general picture, but it's not going to give us a 2002 look.

DR. ROWE: I wanted to comment on the finding with respect to race. A couple things.

One is some years ago, I know Bruce Vladeck and others

published a paper out of then-HCFA looking at racial and ethnic disparities in Medicare beneficiaries. My understanding was that the variables in that study were importantly influenced by socioeconomic conditions. I think they used both data on income individually and a proxy based on metropolitan statistical area or something like that. And both ways it was significant.

We might comment on that a little bit, that if there is an access problem with respect to race it may be aggravated by socioeconomic conditions. Or just look at that paper.

Secondly, I wanted to point out the general issue of racial and ethnic disparities, there was an IOM report that you no doubt saw called Unequal Treatment or something like that -- in fact, I think my fellow commissioner Alan Nelson chaired, that came out earlier this year on racial and ethnic disparities, which is obviously an apparently durable, sustaining, intractable, serious problem that we have in this country in our health care system.

There have been studies supported by the Commonwealth Fund, by Arnie Epstein recently and others, looking at quality of care and Medicare+Choice beneficiaries. And these people are insured and they have a doctor. And they still found racial and ethnic disparities in usual HEDIS measures of quality of care, beta blockers after myocardial infarction, follow up after mental health hospitalization, et cetera. Really very disturbing findings.

Now what we're finding here, not in the study of quality, but in the study of access in the Medicare program, we're also finding these kinds of issues. I think that it would be good, as you write this up, one of our problems is that we're at risk for looking at the racial and ethnic disparity issues and seeing it in a bunch of silos. So it gets a little mention here and a little figure, because it's access. And then in the quality chapter there's a little mention of it.

But we should point out that this is a problem that spans the program and different aspects of health care. And maybe we can raise it to a level where it will get more attention.

I'm not suggesting CMS isn't very concerned about it, but I'm just saying obviously we haven't solved this problem. I think it's one of the major problems we have. And it would be nice to have some texture around the socioeconomic issues as modifiers. I don't think they're determinants, but they're modifiers of these findings.

DR. REISCHAUER: I agree with you 100 percent that this is a serious problem and a societal problem and it's something that we should face. But it struck me that the focus of what we're doing here is to try and monitor changes in access over time. The reason one would want to look at racial minorities or rural populations or inner cities would be that access problems might show up sooner there than elsewhere. But these are two, in a sense, different issues.

DR. ROWE: The canary in the mine shaft.

DR. REISCHAUER: Yes, right.

DR. ROWE: They certainly are particularly susceptible, apparently. They are at risk, yes.

DR. REISCHAUER: There's good reason to focus on them but

the issue isn't that day in and day out their care is less --

DR. ROWE: But if they are going to be identified as a leading indicator, let's say over time, then it is worth doing the socioeconomic analysis because you could identify the subset, not just at a given racial/ethnic background, but economic that would, in fact, be the most sensitive subset. Right?

DR. NEWHOUSE: Is it right that these have fluctuated more for the minorities than the non-minorities over time? So this is a hypothesis.

MS. RAPHAEL: I just wanted to follow up because I think there are two important things here. One is this not having a usual source of care, I think, is very, very important because that is very costly to the health care system. It just plays out in so many ways, not only using the ER as your primary care center. But in home health care we find we have 10 to 20 percent who don't have a usual physician. You can't get anyone to really oversee the services, to even prescribe the services. Because someone comes in who broke a hip, but there's no physician to whom they're attached. And so I think that really is a very important issue in all of this.

And then I was struck to what extent that connected with the people who were in poor health who were five times more likely to have issues around access. To what extent are they the same group that don't have the connection or a usual source of care?

MR. HACKBARTH: We're going to have to move on here in a just a second. Let me ask a question about your big picture here.

This is very impressive in the scope and its depth, and doing this sort of work will lead to lots of interesting findings worthy of discussion. And we've got another problem that Bob was referring to, of trying to monitor a fairly large set of services for changes.

So what I'm struggling with is depth versus breadth in what we do. Can we afford to go so deep when we need to be able to identify important changes in access over a large number of services? How do we get the most bang for our resources in looking at access issues?

MS. MILGATE: Let me take a stab at that and then maybe Mark or Lu want to comment, I'm not sure.

The way that we've thought about it on the access team is that we hope that some of this, particularly in step one here where we're doing kind of a scan of the beneficiary needs and supply of services, would become somewhat routine over time. The first time we did it we would have to find the data sources, collect the data, and paint a general picture. Some of the depth in there would also be done in the process of payment updates, but in general this would become hopefully a little more routine over time.

The same way, in some ways, in number two. Number two, for example, when you're looking at the MCBS and the various beneficiary surveys that are out there on their perception of access are data sources that we can go to on a fairly regular basis, as is true of some of the provider surveys and utilization data.

And then you get a little bit more in depth by looking at the distribution issues, which I don't think we'd look at the same things necessarily each year, but perhaps choose a different one. And the comments that I've heard, at least a few of them, have supported that it's important to look at SES, for example, as the relationship between the factors and how income might drive racial differences and that sort of thing.

And then the other deeper one here we've talked about doing is local market analysis.

After that step, though, would be the place where we'd really determine okay, where do we want to dig more deeply into this year, and that we wouldn't go into each of these in the same depth each time we would look at them every year.

So hopefully, the first step would become a bit more routinized over time. The second, you're going to dig in a little bit, but then you would try to narrow it down to a few particular analyses where you might do something in more depth. That's how we've thought about it on the access team.

MR. HACKBARTH: All right. Thank you very much.

DR. REISCHAUER: Just one question. The last time we were discussing this we were sort of toying with the idea of whether we could use payment information to provide more contemporaneous index of service utilization, like quarterly office visit claims or something like that.

MS. MILGATE: Claims, for example?

DR. REISCHAUER: Is that too messy?

MS. MILGATE: CMS is actually developing a database to be able to do that on a very real-time basis with physician data. They have county level. And they are still developing that. We're talking to them pretty regularly about how we might work with them to use that, as well.

DR. MILLER: Just to follow up on Bob's question, isn't in box number two, some of the broad measures and the utilization data, that's where that data would show up?

MS. MILGATE: Yes.

DR. MILLER: So we are contemplating it to the extent that we can get the data and make it --

MS. MILGATE: Yes, and then the specific would be the CMS example.

MR. HACKBARTH: Thank you.